ABOUT PATIENT-CENTERED MEDICAL HOMES (PCMH)

SOUTH DAKOTA CARDIOVASCULAR COLLABORATIVE

IN THIS CHAPTER:

What is a Patient-Centered Medical Home?[11]

The patient-centered medical home (PCMH) is sometimes referred to as a medical home or advanced primary care. It is a model or philosophy of primary care that is:

- Patient-centered
- Comprehensive
- Team-based
- Coordinated
- Accessible
- Focused on quality and safety

"In the PCMH model, treatment is coordinated through the patient's primary care physician to ensure the patient receives care when and where they need it and in a way that they can understand it."

This model encourages providers and care teams to meet patients where they are and treat patients with respect, dignity, and compassion. The PCMH is designed to improve patient experience, improve population health, and reduce the cost of care. PCMH has become a widely accepted model for delivering primary care, with nearly 500 public and private PCMH initiatives being tracked across the U.S.

Although there are differences in terms of how each practice implements and measures the PCMH attributes, most PCMHs incorporate a team-based care approach, with clinicians and staff working at the top of their skill set.

"Practices provide care coordination that helps patients – especially vulnerable ones – navigate the 'medical neighborhood' of specialists, hospitals, home health, and other health care ancillary services."

The practice also connects patients to community resources that support their health and well-being. While providing this type of advanced primary care, the practice focuses on enhanced trusted relationships with patients, families, and caregivers, by keeping them at the center of this model.

What elements define a Patient-Centered Medical Home?

According to the Agency for Healthcare Research and Quality (AHRQ), the PCMH approach delivers primary care that is:

- **Patient-centered:** A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
- **Accessible:** Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access and strong communication through health IT innovations.
- **Committed to quality and safety:** Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

The American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and American Osteopathic Association developed these Joint Principles for PCMH:

- Whole-person care, which includes provision of comprehensive care and self-management support and emphasizes the spectrum of care needs, such as routine and urgent care; mental health; advice, assistance and support for making changes in health habits and making health care decisions
- Personal clinician provides first contact, and continuous, comprehensive care; preventive care is a key component
- Care is coordinated or integrated across the health care system
- Team-based care

Do all Patient-Centered Medical Homes work the same way?

Most PCMH primary care practices strive to incorporate all the attributes listed above; however, the medical home model is not a "one size fits all" framework. In this model, each primary care practice implements these attributes in a way that fits the practice's own unique characteristics. These characteristics include:

- Size of the practice (i.e. large or small)
- Location (i.e. urban versus rural setting)
- Composition (i.e. solo/small practice, mid-size primary care practice, large multi-specialty practice, academic-affiliated practice, etc.)
- Patient population being served (i.e. health status, other social & economic characteristics)
- Whether financial or performance incentives are provided

The infographic on the next page, developed by the Patient-Centered Primary Care Collaborative, explains the patient-centered medical home (PCMH) as you would explain it to a patient:
https://www.pcpcc.org/sites/default/files/page-files/PCMH-PCPCC-Infographic.pdf

Patient-Centered Primary Care COLLABORATIVE

What Is a Patient-Centered Medical Home (PCMH)?

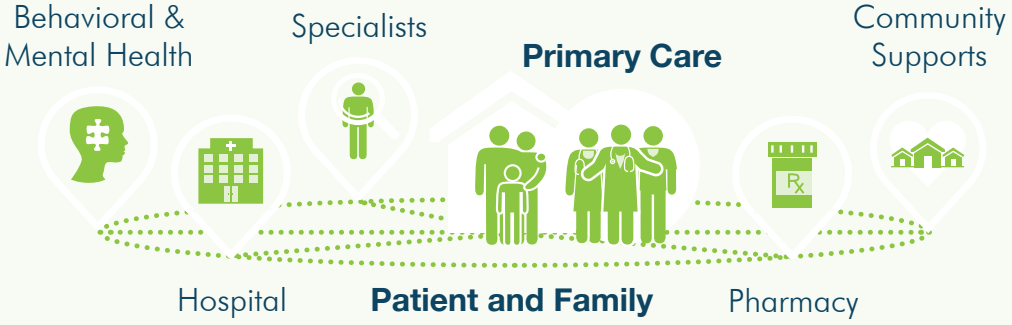
It's not a place… It's a partnership with your primary care provider.

PCMH puts **you** at the center of your care, working with your health care **team** to create a **personalized plan** for reaching your goals.

Your **primary care team** is focused on getting to know you and earning your trust. They care about you while caring for you.

Technology makes it easy to get health care when and how you need it. You can reach your doctor through **email**, **video chat**, or after-hour **phone calls**. **Mobile apps** and **electronic resources** help you stay on top of your health and medical history.

As you pursue your health care journey, you may make stops at different places:



Wherever your journey takes you, your **primary care team** will help guide the way and coordinate your care.

Studies show that PCMH:

Provides better **support** and **communication**

Creates **stronger relationships** with your providers

Saves you **time**

To learn more about the PCMH, visit **www.pcpcc.org**

A Patient-Centered Medical Home is the right care at the right time. It offers:

Personalized care plans you help design that address your health concerns.

Medication review to help you understand and monitor the prescriptions you're taking.

Coaching and advice to help you follow your care plan and meet your goals.

Connection to **support and encouragement** from peers in your community who share similar health issues and experiences.

Who can provide PCMH Services?[12,13]

Primary care physicians represent most PCMH-recognized practices – including family practitioners, general practitioners, internists, and pediatricians. Most primary care practices have the potential to become PCMH-recognized regardless of their size, configuration, electronic capabilities, populations served or location. The National Committee for Quality Assurance (NCQA) has three levels of PCMH recognition that reflect how extensively practices meet the criteria and allow diverse practices to meet requirements and become what their patients want them to be.

As long as a practice can demonstrate that it provides whole person care and meets the elements of the Joint Principles listed previously for at least 75 percent of its patients, it can be eligible for PCMH recognition by NCQA, even if it is not a traditional primary care practice.

What about specialty practices?

Specialty and subspecialty practices such as OB-GYN, oncology, cardiology, endocrinology and mental health clinics have inquired to NCAQ and state that they are a patient-centered medical home to a subset of their patients, either temporarily or permanently.

What about specialty practices that don't fully meet the criteria for PCMH recognition?

Clinicians who are not eligible to participate in the PCMH program may be eligible for NCQA's Patient-Centered Specialty Practice (PCSP) Recognition Program, which extends the medical home concepts to specialists. This allows specialty practices committed to access, communication and care coordination to earn accolades as the "neighbors" that surround and inform the medical home and colleagues in primary care.

Practices that become PCSP recognized demonstrate patient-centered care and clinical quality through:[12]

- Streamlined referral processes and care coordination with referring clinicians
- Timely patient and caregiver-focused care management
- Continuous clinical quality improvement

How does a practice become a PCMH?[11,14]

The process of implementing the PCMH model of care is often called "practice transformation" because the changes touch every aspect of the practice, including the culture, and the changes begin incrementally.

The Patient-Centered Primary Care Collaborative (PCPCC) strongly recommends that facilities begin their transformation efforts in partnership with patients and/or family caregivers from the practice. Patients and families can be powerful partners in helping guide improvement by prioritizing strategies that will have significant impact on helping their practice become more person/family-centered.

Although there is variation in approach, most experts suggest practices use the following approach:

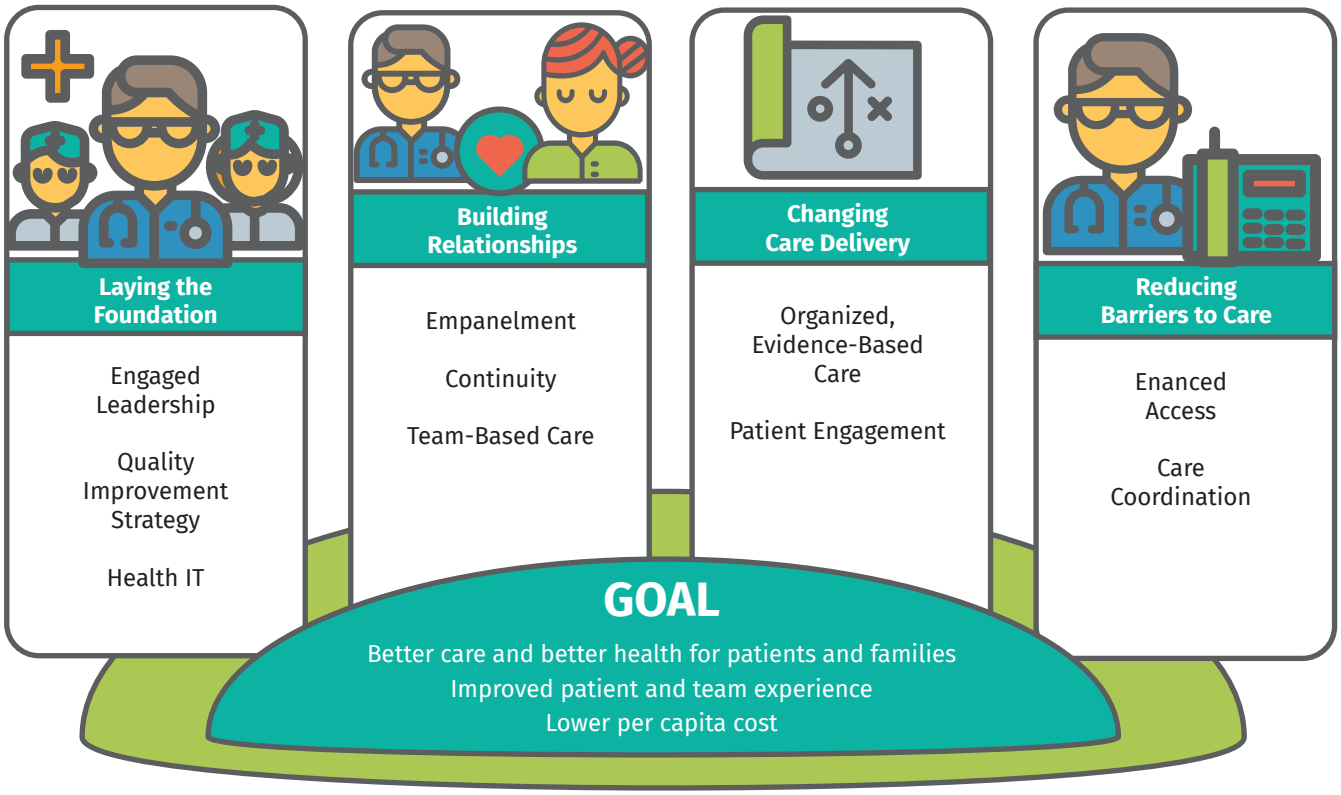
- **Step 1:** Conduct a self-assessment to identify assets and gaps. For example, practices that have already implemented an electronic health record system would be better positioned for PCMH transformation.
- **Step 2:** Adopt structural and organizational leadership changes. This includes looking at the facility, personnel, technology, and engaging with patient and family advisors.
- **Step 3:** Adopt workflow/process modifications. Pay attention to team building, efficiency of operations, and care coordination.
- **Step 4:** Assess process and outcome improvements. Look for improvements related to quality, cost and patient and clinician experience.

The practice transformation process typically takes between 18 months to 3 years and requires a focus on continuous improvement and learning. However, the transformation can result in great improvements in patient care, staff satisfaction, and cost savings.

Qualis Health has developed the Pathway to Practice Transformation framework as a road map to help practices navigate these changes. This framework is an evidence-based, sequential model designed to help practices achieve three primary goals:

- Better care and better health for patients and families
- Improved patient and team experience
- Lower per capita cost

The Pathway to Practice Transformation framework has been used by organizations of many sizes and types, from small practices to complex health systems to Medicaid agencies.



Learn more here: http://practicetransformation.qualishealth.org/our-framework

What is PCMH recognition?

There are several entities that "certify" or "recognize" practices as PCMH, including national accrediting bodies, health plans, and state agencies. Many PCMH practices – but certainly not all – choose to become "certified" or "recognized" by an outside entity.

PCMH recognition programs vary in the amount of required documentation, application costs and overall efforts. This can enhance the practice's ability to obtain increased reimbursement, if there are payers in their marketplace that offer it. Three accrediting bodies are described here (note: inclusion of these accrediting bodies does not imply endorsement).

- Association for Ambulatory Health Care Medical Home On-Site Certification
    1. Medical Home On-Site Certification evaluates a practice against AAAHC Standards for a Medical Home. The On-Site Certification program includes consultative support for your organization before, during, and after the survey.
    2. Offers two programs – full accreditation with Medical Home, and Medical Home On-Site Certification. Pricing for each is based on the size and scope of services of the practice applying. A small primary care practice might anticipate a total cost of about $2,500 for Medical Home On-Site Certification. A similar practice attempting full AAAHC accreditation including Chapter 25 on Medical Home could range from $6,400-$8,000. A $775 survey fee is added to either option.
    3. Learn more about Medical Home On-Site Certification here: http://www.aaahc.org/accreditation/primary-care-medical-home/

- The Joint Commission's Primary Care Medical Home Certification
    1. Focuses on care coordination, access to care, and how effectively a primary care clinician and interdisciplinary team work in partnership with the patient.
    2. Emphasizes educating patients and encouraging them to self-manage their conditions or diseases.
    3. Surveyors perform an on-site review to assess compliance with standards and provide education and guidance to help staff continuously improve performance.
    4. Indian Health Service hospitals are required by policy to obtain this certification.
    5. Learn more about TJC Certification here: https://www.jointcommission.org/accreditation/pchi.aspx
- National Committee for Quality Assurance Recognition
    1. Participation in an NCQA Recognition Program demonstrates that the practice or clinician values quality health care delivery and the latest clinical protocols to ensure patients receive the best care at the right time.
    2. Certification fees are based on the number of physicians in a practice and can range from roughly $600 for a solo practice to more than $4,000 for a practice with eight or more physicians. Learn more here: http://www.ncqa.org/programs/recognition/ncqa-pcmh-pcsp-recognition-program-pricing
    3. Learn more about PCMH Recognition here: http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh
- URAC PCHCH Accreditation
    1. URAC is a nonprofit organization responsible for granting national accreditation to healthcare organizations. URAC accreditation is a highly coveted achievement which represents a commitment to quality and patient safety.
    2. Achievement program cost varies depending on size and organization type, as well as the length of the on-site audit, but ranges from $2,500-$6,000.
    3. Learn more about the benefits, resources available, and how to achieve accreditation here: https://www.urac.org/programs/patient-centered-medical-home-certification